ORIGINAL STATE HEALTH PLAN

DELAWARE MEDICAID MANAGED CARE

1115 WAIVER

PROTOCOL DOCUMENT

ORIGINAL 9/22/95
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INTRODUCTION

Terms and Conditions: Item # 3

> "The State shall prepare [a] protocol document that represents the policy and operating procedures applicable to this demonstration which have been agreed to by the State and HCFA. "

Section I Organizational and Structural Configuration of the Demonstration Arrangements

1. Overview:

2.02

The Diamond State Health Plan seeks to demonstrate that it is possible to control health care costs and expand access to health care by redefining governments role, coordinating and utilizing the competitive forces of the private sector and encouraging empowerment of a population to make key decisions regarding their own health status.

The State of Delaware seeks to:

Improve and expand access to health care to more adults throughout the State.

Create a managed care delivery system, with an emphasis on primary and preventive care in all three counties in Delaware.

Control the growth of health care expenditures for the Medicaid population.

The State of Delaware will use the following methods to achieve the above goal:

Provide a comprehensive, standard benefits package of physical and behavioral health services.

Provide outreach and education to vulnerable populations throughout the Medicaid enrollment process.

Encourage the appropriate utilization of Medicaid and behavioral health services, especially the use of the emergency room.

Emphasis a managed care approach to create a continuum of care and services.

The State will combine into one pool the following populations to be served by the Diamond State Health Plan;

The current AFDC-related groups, including;

SSI-related groups (excluding dual Medicaid-Medicare eligibles)

The State Funded General Assistance group (GA Health First)

All other uninsured residents who are at or below 100% of the Federal Poverty Level (FPL).

Pregnant women and children up to age one, at **185%** of the FPL, and Children up to age 6, at 133% of the FPL, are included as categorically eligible and, therefore, are covered in the plan.

The following services are not included in the DSHP and will continue to be reimbursed be the State as fee-for-service:

Pharmacy

Non-emergency medical transportation

Extended behavioral health benefits

Services for those populations not eligible for the DSHP

2. Organizational Structure

The introduction of managed care to the Medicaid population impacts a board range of State agencies, advocacy and community groups, other Medicaid providers and, most importantly, the Medicaid client. State agencies, e.g. Division Public Health, the Division Child Mental Health and the Division of Alcohol, Drug Abuse and Mental Health will need to make fundamentally different changes in the way they delivery services in a capitatied, pre-paid environment.

The State will contract with a Health Benefits Manager (HBM) to provide enrollment, education and outreach for the Medicaid population. The State will also contract with Managed Care Organizations (MCO) to deliver health care services to the Medicaid population using existing provider panels and networks.

Diamond State Health Plan, Delaware's Medicaid Managed Care program is part of the Division of Social Services, Delaware Department of Health and Social Services. The Secretary of the Department of Health and Social Services is a member of the Governor's Cabinet. The Secretary of the Department of Health and Social Services is also responsible for the Division

Public Health, the Division of Alcohol, Drug Abuse and Mental Health, as well as other health and social service related divisions.

The Project Director for the Diamond State Health Plan is the Chief Administrator for Managed Care. This position reports to the Deputy Director Medical Assistance, Division of Social Services.

Reporting to the Chief Administrator are a Cost Containment Specialist for Health Benefits Management, a Cost Containment Specialist for Managed Care Organization, a Supervisor for Program Coordination and an Administrative Assistant I. Other duties and responsibilities related to program implementation are coordinated among the other four Chief Administrators in Medical Assistance and their staff The Chief Administrator Managed Care works closely with this group to facilitate implementation. Monitoring, evaluation, data collection, contract management, eligibility determination and budgeting and policy development are fbnctions of these other components.

An Organizational Chart is attached. (Attachment A)

Section II Organization of Managed Networks

1. Managed Care organization:

The State will contract, on a capitated basis, with several Managed Care Organizations (MCOs) to Implement the Diamond State Health Plan. We will contract with at least two MCOs in each of Delaware's three counties, to fulfill the requirements of the Terms and Conditions. We may contract with at least two statewide MCOs. We will contract with as many MCOs as necessary to provide capacity for the expected 63,000 + Medicaid beneficiaries, as long as the MCOs meet the Terms and Conditions of the State's RFP and contract.

The MCO must be licensed as a Health Maintenance Organization (HMO), Health Services Corporation or "like entity" by the Delaware Department of Insurance and meet all of the requirements of this Department, prior to contracting with the State as an MCO in the Diamond State Health Plan.

The majority of the MCOs with licenses or Certificates of Need, in Delaware, are direct contract Individual Practice Association models (IPAs). As such, the MCO contracts directly with the providers of service, either on a capitated or fee-for-service basis. At this time, the majority of reimbursement mechanisms are fee-for-service.

The providers may contract with any or all of the licensed MCOs and are not, in most cases, restricted to one MCO.

The MCOs will be required to deliver the Medicaid benefit package as described in the MCO RFP. This will include EPSDT Services, as well as some important State programs, Smart Start and Home Visiting programs. Mental Health, Substance Abuse and School Based Services will be provided and coordinated through the MCOs with various State Agencies.

Delaware contains one very urban county, New Castle, and two very rural counties, Kent and Sussex. Access to health care is extremely limited in Sussex county and transportation is an ongoing problem. MCOs are asked for creative and innovative approaches to the twin problems of access and transportation, particularly in our southern counties.

The State will develop an automated system to monitor enrollment and provider capacity. This system will also be used to auto-assign members who do not chose an MCO within 30 days of notification.

2. Service Providers 4.06

The MCO have 30 days from the date of enrollment to assure that the DSHP member has selected a Primary Care Provider (PCP). PCPs may be from the following specialties:

Family Practice
General Medicine
Pediatrician
General Internist
OB/GYN (at the option of the MCO)
Family Nurse Practitioner
Nurse Midwife (at the option of the MCO)

MCOs must provide monthly updates and documentation of their service provider network. PCP update will be automated and will update the MCO Capacity file, on a monthly basis. The MCO must assure that their providers do not discriminate on the basis of age, gender, race, sexual orientation, physical or mental handicap national origin, health status or need for health services.

A PCP provider panel may not close to just Medicaid clients, if a panel closes it must close to all members.

MCOs should limit PCP panels to **2500** members unless the State approves larger panels.

Section III Payment Mechanism

1. Health Benefits Manager

The Health Benefits Manager (HBM) will be reimbursed by the State on a negotiated contract. Contracts will be based on a annual rate period and renewable for three years.

2. Managed Care Organizations

The MCOs will be reimbursed by the State on a tiered, capitated rate. The tiered rates are attached as part of this protocol document (see Attachment B). The MCOs may negotiate any reimbursement method with their contracting providers as the providers and the MCOs decide acceptable. The State will monitor that the MCOs are paying their providers promptly and adequately to assure a network capable of delivering care.

The tiered rates are adjusted for managed care savings, as well as TPL. The MCOs will be responsible for Third Party Liability (TPL) and will work with the HBM and the State to provide information for TPL reporting..

The MCOs will be required to carry reinsurance on this population, the State will not reinsure the MCOs.

The Department of Health and Social Services will make the capitated (per member per month) payments no later than the fifth working day of the month using the present fiscal agent process. The Medicaid Management Information System *(MMIS)* will be utilized for all payment tracking, monitoring and evaluation.

Section IV Benefit Package

The attached grid (Attachment C) highlights the State's existing Medicaid benefit package. In addition, the MCOs will be responsible for the delivery of the existing Smart Start program for high risk mothers, the Vaccine for Children program and the Home Visiting program, for early maternity discharge, and for services delivered through FQHCs. In addition, the MCOs will be responsible for EPSDT benefits, except Dental.

The MCOs will also be required to reimburse providers for the freedom of choice benefits, family planning and medical emergencies, as well as authorized out of network services. MCOs will also be required to coordinate MH/SA and school based services with State agencies responsible for dealing with the delivery of those services.

1. Covered services include, but are not limited to:

4.01

Physician Services

Consultations
Eye Exams
Family Planning
Hospital visits
Immunizations
EPSDT services, except Children's Dental
Office visits
Allergy Treatment
Obstetrics/GYN services
SNF Visits

Other Services

Inpatient Hospital
Outpatient Hospital
Emergency Room
Diagnostic and Therapeutic Services
Home Health and Home visits
Emergency Ambulance
Medically necessary durable medical equipment.

2. Services not covered by Medicaid Managed Care

Dental
Pharmacy
Extended Behavioral health care
Non-emergency Transportation

These services continue to be provided by the State and will be reimbursed as fee-for-service.

3. Populations excluded from Medicaid Managed Care

Persons in the Long Term Care (LTC) program
Persons selecting other existing waivers programs, i.e., Home and Community Based
Dual Eligibles, persons with Medicare and Medicaid
Persons with other accessible managed care insurance

Services for these populations will continue to be provided by the State and reimbursed as fee-for-service.

Section V Medicaid Eligibility Process

"...implement procedures so that hospitals will be able to distinguish between individuals eligible for Medicaid ...through the expanded eligibility and all other Medicaid eligibles."

1. Eligibility Determination

Determination of initial Medicaid eligibility, redetermination of continued eligibility, and on-going case maintenance (i.e., change of address) are the responsibility of the Division of Social Services. Specifically, the Family and Community Medicaid Unit, Long Term Care Unit, the SSI Community Related Medicaid Unit, and the Financial Services Operation Unit within the Division have the following responsibilities:

A.) The Family and Community Medicaid Units

The Family and Community Medicaid Units determine financial eligibility for AFDC-related or special program applicants such as:

Pregnant women and children who have income greater than the AFDC standard

Foster children

Disabled children whose parents have too much income for them to receive Supplemental Security Income (SSI)

The new group of uninsured adults with income at or below One hundred (100) percent of the Federal Poverty Level (FPL) for eligibility for the Diamond State Health Plan

Besides determining initial eligibility, these units also periodically redetermine eligibility. They are the primary contact with the Medicaid eligible population for resolving a wide variety of problems related to their cases.

The new expanded population will be assigned new, specific aid categories that will allow the State and the MCOs to distinguish this population form the categorically eligible population. The State and the MCOs will have the ability to run reports for the hospitals, when necessary, to isolate this population fiom the categorically eligible.

It has been their responsibility to obtain information regarding other medical insurance (third party liability-TPL) and communicate this information by completion of Form COB-1, or by memo to the Medicaid TPL unit. They make appropriate referrals to other agencies for assistance in meeting the applicants/clients non-medical needs.

Under the Diamond State Health Plan the HBM will collect this information and transfer it to the MCO and the State. The MCO will also collect TPL information and will share this information with the HBM and State agency.

Finally, under the DSHP, they will briefly explain that all recipients (except those specifically excluded such as applicants with accessible managed care benefits or Medicare beneficiaries) will be contacted by HBM to choose a managed care plan.

B.) The Long Term Care Units

The Long Term Care Units determine financial and medical eligibility for:

Nursing home care

Home and community-based services

Over thirty (30) day inpatient hospital services

These units also complete redeterminations of eligibility and the same type of problem resolution as the Family Medicaid Units. Persons eligible under these programs are not eligible for the DSHP.

C.) The SSI Community Related Medicaid Unit

The SSI Community Related Medicaid Unit has responsibility for determining eligibility of clients who are SSI related in the community, but who do not meet the criteria to qualify for long term care. SSI/community related applications are made for:

Widows and Widowers

Adult Disabled Children

Adoption Subsidy

Adoption Assistance

This unit completes the data entry processing for issuance of Medicaid cards for beneficiaries of Supplemental Security Income (SSI) and State Supplemental Payment (SSP). Eligibility for these programs is determined by the Social Security Administration. Information necessary for initial authorization, continued eligibility, and case maintenance is passed monthly via tape from Social Security Administration to Medicaid SSI unit.

Persons eligible under these programs may be eligible for the DSHP and for these persons, this Unit will provide them with the HBM information.

D.) The Financial Services Operation Units

The Financial Services Operation Units have the responsibility for determining client eligibility for the Aid to Families with Dependent Children (AFDC), AFDC-Unemployed Parent AFDC-UP, General Assistance (GA) and Food Stamps programs. In relation to Medicaid, their responsibilities include:

Assuring there is a signed application form for each applicant

Obtaining information regarding other medical insurance (third party liability-TPL) and communicating this information by completion of Form COB-1 or by memo to the Medicaid TPL unit In addition this information will be shared with the HBM and the MCOs.

Informing each eligible client about Medicaid services by distributing Medicaid Program User Guides and information relating to the DSHP and the HBM.

Reviewing DCIS turn-around documents to assure that the grant calculator has taken appropriate action and produced timely notice when taking a negative action on a case, such as a closing or rejection

Making appropriate referrals to the Family Medicaid Units when AFDC or AFDC-UP cases are denied or closed

Establishing a Medicaid case on DCIS for each individual who receives an AFDC or AFDC-UP benefit.

2. Medical Eligibility/Disability

Certain programs require a medical professional to certify that an applicant meets the specific program definition of medical need or disability. Examples are:

Pregnant women must have proof of pregnancy due date

Disabled children must meet disability and Level of Care requirements

Long-term care applications must meet the skilled or intermediate nursing level of care

Depending upon a program's specific requirements, either DSS or another health care professional can perform the certification.

3. Changes and Redetermination of Eligibility

Except for the SSI only unit which has statewide responsibility, clients apply and report all changes to a designated location. The client or his/her representative will be required to report any changes in status (death, change in residence, family size, income, job status, etc.) to the State.

Interim changes may cause the client eligibility to terminate. Except for death, moving out of State or a client's request, eligibility is terminated on last day of the month.

Additionally, the State will conduct annual recertifications of client's records to determine whether there has been any change in status and eligibility. When a client's eligibility status for the DSHP changes, DSS will enter the information into the automated system which will advise the HBM of the change. The HBM will then notify the MCOs. MCOs will also be required to notify DSS and the HBM if they become aware of any changes in status or eligibility. This process will be available of the new "income" eligible expanded population.

4. Locations

The HBM will have a local, to Delaware, office and 1-800 telephone availability. While this office will be located in New Castle county, the HBM Project Manager and the HBM Representatives will be available in many areas of the State. The HBM has requested temporary officespace in the FQHCs and many community

centers. The HBM expects to be available at banks, stores, Laundromats, etc. to provide for access for education, outreach and enrollment for the Medicaid population.

It is expected that in some circumstances the HBM will be co-located with the DSS units that determine and redetermine eligibility to facilitate the selection of a MCO by all clients.

Section VI Marketing and Outreach Strategy

",..describe[the State's] mechanism for reviewing all marketing materials ..."

The State shall require the following procedures from the HBM and the Contracting MCOs. Documents for approval will be forwarded to the State's Project Manager who will coordinate with all effected State agencies to review and approve these materials in an expeditious method as agreed upon between the State, the HBM and the MCOs.

The State will implement a Materials Review Team to provide for the review and approval of this information. Information will be distributed to this team as received, the State's Project Manager will coordinate the responses and schedule meetings when necessary, This Team will make every attempt to turn this material around in less than 30 days from date of receipt.

1. Managed care education materials.

The HBM will develop, produce and utilize materials that inform all clients (both existing Medicaid clients and new eligibles) in the target population about managed health care systems. All managed care education material must clearly:

- Explain the benefits of managed care organizations, and the ways in which managed care is designed to address health care needs.
- Explain how to access services in a managed care system, including emergency services, family planning services, transportation, pharmacy services, and mental health and substance abuse services.
- Explain the role and responsibility of the primary care provider in a managed care system, and the importance of maintaining existing appropriate relationships with primary care providers.
- Explain the benefits of preventive health care and prenatal care, and the availability of EPSDT services, and Smart Start, where appropriate.
- Explain the availability and use of the toll fiee telephone system.
- Notify the client of the requirement to choose a health plan within thirty (30) calendar days of the postmark date that an enrollment form was sent to the client. Clients must also be informed that, in absence of receipt of a stated choice within 30 days, they will be automatically enrolled into one of

the participating health plans. The **HBMs** initial notification will contain the name of the pre-selected MCO.

- Explain which services are available under the Diamond State Health Plan. Contractor staff and enrollment materials must clearly:

  - Inform Medicaid clients in the target population about the timing and nature of planned changes in the way that Medicaid health care services will be accessed and delivered.

  - Provide basic educational information about how health care services are delivered under managed care.

  - Inform clients of their rights and responsibilities under managed care, including where and how additional information can be obtained.

  - Maximize the incidence of voluntary enrollment into health plans.

  - Explain the services that are provided by the health plan and the appropriate way in which to access those services. The relevant ways in which health plan options differ with respect to coverage and procedures must be explained.

  - Explain the appropriate circumstances and relevant guidelines for obtaining covered health care services outside the health plan network.

  - Explain which services are not covered under the health plan, but are covered by Medicaid, and how those services may be obtained either within **or** outside a health plan network.

  - Explain the responsibilities of the client in following established health plan procedures for seeking emergency and non-emergency services, making appointments with the primary care provider, seeking hospital admissions, circumstances under which self-referral is appropriate, and the need to adhere to prescribed treatments as indicated by the primary care provider **or** other health plan provider.

2. General requirements.

The HBM will design and produce the following materials for use in the education and enrollment activities. All materials developed by the HBM must be approved by the State agency prior to production, distribution or incorporation into contractor education and/or enrollment activities. Printed material should be oriented to the target population, and understandable at the sixth grade reading level. All printed materials must also be produced in Spanish. The materials may also be produced and distributed in other media formats as deemed most effective by the HBM to accomplish specific objectives within the outreach, education and enrollment processes. The content and volume of all materials, whether printed or distributed via other formats, must be adequate to accomplish the stated goals of the campaign, and be designed to address the informational needs of those clients who speak languages other than English or Spanish, those with visual or hearing impairments, or those whose literacy level renders printed materials less than effective.

A.) HBM Enrollment materials.

The HBM will develop, produce and/or utilize enrollment application forms, information and instruction sheets, brochures and handbooks as necessary in order to facilitate client enrollment and maximize the informed selection of health plans. The enrollment forms should be pre-filled in with all available and pertinent information about the client. The method of returning this information via mail to the contractor must be postage-free to the client, and minimize the cost to the contractor and the State. In addition to materials designed to collect all other necessary enrollment data, the enrollment materials must also contain the following information:

a.) Clear and concise instructions on how to complete the enrollment form, including information about deadlines for returning the completed form, and

b.) the name of the pre-selected MCO, should the auto-assignment function occur

B.) MCO Materials

The MCOs will not be permitted to do direct "one-on-one" marketing to the Medicaid eligible population. However, they will be permitted to distribute general information during health fairs, community meetings and through the HBM.

Marketing material supplied by the contracted Managed Care Organizations will **be approved by the State agency prior to distribution. The HBM contractor** will **include this information without alteration or supplementation.**

Section VII Enrollment Process and HBMs

"...a detailed description of the Health Benefits Manager (HBM). [including] qualifications and training procedures...and procedures for auto-assignment [as well as] a plan to monitor HBM performance."

The overall goals of the HBM program are to:

Ensure that educational information is available to all clients to inform them of the use of a managed care delivery system, and the benefits and health plans available under the Diamond State Health Plan;

Assist clients in the process of selecting a health plan and, where possible, a primary care provider in a manner which ensures an objective, factual presentation of all enrollment options;

Respond to client inquiries, complaints, requests for information and requests for transfers to other health plans; and

Act as a client advocate in the resolution of problems and removal of barriers in accessing necessary health care services.

1. Scope of Work.

A.) Enrollment activities.

Enrollment phases.

Because the Diamond State Health Plan seeks to enroll both a majority of the current Medicaid population and new clients as they are determined eligible for the program, the HBM will undertake enrollment activities in two distinct phases.

a.) Initial conversion phase!.

As part of the conversion to the Diamond State Health Plan, the HBM will enroll at least fifty (50) percent of all current Medicaid clients in the target population into health plans prior to the first day of the official implementation of the Plan, and the remaining fifty (50) percent within one (1) calendar month of the Plan's implementation date. It is anticipated that the methods and resources employed by the HBM during the initial conversion phase will differ significantly from those used during the ongoing enrollment phase.

During the initial conversion phase only, as a precursor to the client enrollment process, the HBM will perform the following outreach services:

Client advance notice.
Before soliciting enrollment information, the HBM will distribute advance notice information regarding the changes in the Medicaid system to all existing Medicaid clients in the target population. The HBM will determine the most effective methods to utilize for this process. All existing Medicaid clients will be mailed an initial announcement packet that contains this advance notice information. This packet may be mailed to the head of a family unit for all members of the family unit, as indicated in the State's records.

The information contained in the advance notice mailing will also be available via the toll fiee telephone system.

The advance notice materials will be sent to clients no later than three (3) business days after receipt of any and/or all file(s) of potential enrollees fiom the State agency.

In-person sessions.
In order to maximize opportunities for client education, the HBM will develop a plan to provide clients with opportunities for in-person contact with HBM staff in group sessions. These group sessions will be carried out in a manner determined most effective by the HBM. These opportunities may be presented in schools, churches, community service centers, public housing sites and other venues, or in the client's home. State service centers will also be utilized by the HBM to conduct in person sessions, at the discretion of the State agency.

The circumstances under which clients may request or be invited to attend an in person session with HBM staff include:

A specific request by a client.

The determination by HBM staff that there is a significant probability that the client will not complete and return the enrollment application and make an informed choice without in person intervention by HBM staff.

A meeting arranged by the HBM in conjunction with and at the request of a client advocacy group or community service agency.

b.) Ongoing enrollment phase.

The HBM will perform the following services during both the initial conversion and the ongoing enrollment phases.

The HBM will be responsible for enrolling into health plans all newly eligible Medicaid clients in the target population. In addition, the **HBM** will process transfer requests and perform all other activities for the entire enrolled population.

Managed care education.
The HBM will design, produce and make available to clients a comprehensive educational program that explains all relevant aspects of the Diamond State Health Plan from a client perspective. **This** education program will be designed to assure that clients gain a complete understanding of managed care in general, and the responsibilities of the client under the new system. Client education materials and services will be integrated with all facets of the enrollment process in a manner which is deemed most effectiveby the HBM in order to enhance client understanding, minimize confusion and optimize the incidence of voluntary enrollment into health plans.

Enrollment process.
The **HBM** will receive daily fiom the State a roster of all potential program enrollees via electronic media. During the ongoing enrollment phase, this roster, or file, will contain all individuals in the target population who were actually determined eligible for Medicaid during the previous processing period.

The enrollment process will be accessible to clients by both mail and by toll fiee telephone using staff in the direct employ of the **HBM.**

Distribution of enrollment application.
The HBM will distribute to all clients by mail and/or other suitable means a managed care enrollment application. The capability to enroll in the program will also be available via the toll free telephone system, and may also be available via other methods as deemed most effective by the **HBM.** During the initial conversion phase, the enrollment materials must be mailed no later than five ***(5)*** business days after the mailing of advance notice materials. During the ongoing enrollment phase, the enrollment materials must be mailed no later than three (3) business days after receipt of the roster of potential enrollees fiom the State.

The enrollment packet and telephone enrollment and information support process must provide the following information and accomplish the following activities:

Present health plan choices.
The HBM will inform the client about all health plans available under the Diamond State Health Plan. This information will be provided in an objective, non biased fashion that neither favors nor discriminates against any health plan or health care provider. The importance of early selection of a health plan should be stressed, especially if the client indicates priority health needs. The HBM will also maintain and make available, both by mail and toll free telephone, provider directories to assist clients in identifying health plans of which a particular provider is a member.

Assist in selection of health plan.
The HBM will assist clients with selection of a health plan that meets their needs by explaining in a strictly non-biased manner criteria that may be considered when making a choice of health plans. Medicaid clients who are eligible for the Diamond State Health Plan will have thirty (30) calendar days from the postmark date that an enrollment form is sent to them by the HBM to select a health plan. All members of the same family will be encouraged to select the same health plan. However families are not required to enroll in the same health plan.

Auto-Assign Function.
When the daily enrollment list is run for the HBM enrollment function an MCO will be pre-selected for the member. That MCO will be identified on the Enrollment form when it is mailed.

The MCO is pre-selected based on the member's Zip-Code area and the availability of PCPs in that area. Preference will be given to MCOs who have contracted with providers of essential community services.

When the above 30 day period has expired and there has been no activity on the part of the HBM to enroll a member, the MMIS will Auto-Assign the member to the pre-selected MCO.

Preliminary assistance in selection of a primary care provider.
The chief responsibility for assignment of clients to primary care providers lies with each respective health plan, after enrollment. However, as a standard part of the enrollment process, the HBM

Identify potential excluded clients.
Excluded clients are those individuals in broad categories who are not, by definition, in the target population of the Diamond State Health Plan. To the extent possible, the State agency will screen client rosters to identify and remove clients who meet exclusion criteria before transmission of the file to the HBM. The HBM will routinely inquire, both by telephone and in-person (where applicable) and as part of the mail enrollment process, as to the existence of potential conditions that may exclude the categorically eligible client from mandatory enrollment into the Diamond State Health Plan. If a client indicates that one or more exclusion conditions exist, this information will be collected and transmitted to the State agency as part of the enrollment process.

Identify potential exemption conditions.

applicable) and as part of the mail enrollment process, as to the existence of potential conditions that may exempt the client from mandatory enrollment into the Diamond State Health Plan. If a client indicates that one or more of the exemption conditions exists, this information will be collected and transmitted to the State agency as part of the enrollment process. The State agency is responsible for approving all exemptions. To the extent possible, the State agency will screen client rosters to identify and remove clients who meet exemption criteria before transmission of the file to the HBM.

Handle undeliverable and returned mail.
The HBM will have in place procedures to forward to the State agency all mail which is returned to the HBM as undeliverable due to incorrect addresses within three (3) business days of receipt by the HBM.

c.) Follow up process.
If no choice information has been received by the HBM, then no later than twenty (20) calendar days after the mailing of the enrollment materials, the HBM must contact all clients to remind them about the pending enrollment choice. This notification will be at least via mail, and may also be by telephone or other method. The reminder process should reinforce all appropriate aspects of the educational component of the HBM program.

d.) Automatic re-enrollment.
Clients in the target population who lose eligibility for the Diamond State Health Plan, and regain eligibility within twelve (12) months will be automatically re-enrolled with the same health plan of which they were a member previously. The State agency will perform this process and supply the necessary information to the HBM. The HBM will have in place procedures to systematically send confirmation information to the client.

e.) Enrollment confirmation.
The HBM will perform the following duties after:

receipt of enrollment information from the client;

thirty (30) calendar days have elapsed since the postmark date when the client was mailed an enrollment packet.

processing of a request for health plan transfer.

The HBM will systematically review enrollment information received from the client for accuracy. The HBM will promptly attempt to contact clients to obtain missing enrollment information, or to verify information that may be inaccurate.

The HBM will have in place procedures to process completed enrollment information and transmit the appropriate data elements at least every week to:

The State agency (via electronic media);

The client (via confirmation letter).

All enrollments in the Diamond State Health Plan become effective on the first day of each month, after either the receipt of completed voluntary choice information by the HBM, or the expiration of the thirty (30) day choice period. Completed enrollment confirmation information will be processed and sent to all entities within five (5) business days of receipt by the HBM or the expiration of the thirty (30) day choice period, and no later than five (5) business days before the effective date of enrollment.

2. Materials.

3.13

a.) General requirements.

The HBM will design and produce the following materials for use in the education and enrollment activities. All materials developed by the HBM must be approved by the State agency prior to production, distribution or incorporation into HBM education and/or enrollment activities. Printed material will be oriented to the target population, and understandable at the sixth grade reading level. All printed materials will also be produced in Spanish. The materials may also be produced and distributed in other media formats as deemed most effective by the HBM to accomplish specific objectives within the outreach, education and enrollment processes. The content and volume of all materials, whether printed or distributed via other formats, will be adequate to accomplish the stated goals of the campaign, and be designed to address the informational needs of those clients who speak languages other than English or Spanish, those with visual or hearing impairments, or those whose literacy level renders printed materials less than effective.

b.) Advance notice materials.

The HBM will develop, produce and distribute printed informational materials describing the upcoming changes represented by the Diamond State Health Plan. These materials may be produced and distributed in a variety of media formats as deemed most effective by the HBM in order to reach all existing Medicaid clients

in the target population in the most efficient manner. The materials will be designed to accomplish the following goals and objectives:

Inform Medicaid clients in the target population about the timing and nature of planned changes in the way that Medicaid health care services will be accessed and delivered.

Provide basic educational information about how health care services are delivered under managed care.

Inform clients of their rights and responsibilities under managed care, including where and how additional information can be obtained

Maximize the incidence of voluntary enrollment into health plans.

c.) Managed care education materials. 5.01

The HBM will develop, produce and utilize materials that inform all clients (both existing Medicaid clients and new eligibles) in the target population about managed health care systems. All managed care education material must clearly:

Explain the benefits of managed care organizations, and the ways in which managed care is designed to address health care needs.

Explain how to access services in a managed care system, including emergency services, family planning services, transportation, pharmacy services, and mental health and substance abuse services.

Explain the role and responsibility of the primary care provider in a managed care system, and the importance of maintaining existing appropriate relationships with primary care providers.

Explain the benefits of preventive health care and prenatal care, and the availability of EPSDT services, and Smart Start, where appropriate.

Explain the availability and use of the toll fiee telephone system.

Notify the client of the requirement to choose a health plan within thirty (30) calendar days of the postmark date that an enrollment form was sent to the client. Clients must also be informed that, in absence of receipt of a stated choice within 30 days, they will be automatically enrolled into one of the participating health plans.

Explain which services are available under the Diamond State Health Plan. HBM staff and enrollment materials must clearly:

Explain the services that **are** provided by the health plan and the appropriate way in which **to** access those services. The relevant ways in which health plan options differ with respect to coverage **and** procedures must be explained.

Explain the appropriate circumstances and relevant guidelines for obtaining covered health care services outside the health plan network.

Explain which services **are** not covered under the health plan, but are covered by Medicaid, and how those services may be obtained either within or outside a health plan network.

Explain the responsibilities of the client in following established health plan procedures for seeking emergency and non-emergency services, making appointments with the primary care provider, seeking hospital admissions, circumstances under which self-referral is appropriate, and the need **to** adhere to prescribed treatments **as** indicated by the primary care provider or other health plan provider.

d.) Enrollment materials.

The HBM will develop, produce and/or utilize enrollment application forms, information and instruction sheets, brochures and handbooks as necessary in order to facilitate client enrollment and maximize the informed selection of health plans. The enrollment forms should be pre-filled in with all available and pertinent information about the client. The method of returning this information via mail to the **HBM** will be postage-free to the client, and minimize the cost to the **HBM** and the State. The enrollment materials must also contain the following information:

Marketing material supplied by the contracted managed care organizations. This material **will** be approved by the State agency prior to distribution. The HBM will include this information without alteration or supplementation.

Clear and concise instructions on how to complete the enrollment form, including information about deadlines for returning the completed form.

Instructions on how to obtain more information, including use of the toll free telephone number.

Suggested selection criteria for choosing health plans and primary care providers. The enrollment form should clearly explain that selection of a primary care provider is desirable, but not mandatory at this point.

Information describing the health plan selection that will be the current default choice for the client, if no choice information is received by the HBM by the date indicated.

Information about conditions by which a client may be exempt from mandatory enrollment in the Diamond State Health Plan, and how the client may contact the HBM to petition for an exemption.

e.) Confirmation materials.

The HBM will design and produce materials and processes that facilitate the weekly transfer of information to the State agency and to the client that details every enrollment choice, whether received from clients by mail, in person, or by telephone, or as the result of the default health plan selection process.

The confirmation information that is sent to the State agency and the appropriate health plan must contain, at a minimum, the client's name, address, telephone number, sex, date of birth, Social Security Number, Recipient Identification Number, health plan, primary care provider number (if a selection was made by the client) and the effective date of enrollment in the health plan.

The confirmation letter that is sent to the client must contain, at a minimum, the client's name, address, health plan name and the member services telephone number, primary care provider (if a selection was made by the client), and the effective date of enrollment in the health plan. The letter must describe the automatic assignment process if the client was automatically assigned.

3. Customer service activities.

a.) General customer service activities.

Enrollment staff will be available in sufficient numbers to assist clients in understanding all aspects of the Diamond State Health Plan, managed care in general, and in selecting and enrolling in a health plan. The HBM will have adequate staff available to respond to general inquiries regarding the Diamond State Health Plan, and for the following activities whether by phone or in person:

Offer assistance in completion of all necessary forms, and ensure that forms are as complete and accurate as possible. Specific efforts should be made to obtain complete information.

Conduct follow up phone calls to non responding clients as necessary to minimize automatic assignment into health plans.

Provide language translation services (including sign language) as necessary to facilitate communication.

Forward requested enrollment or other program information to the client within two (2) business days.

Estimate when managed care coverage will begin if the enrollment application is received in the HBM's office by a specified date.

b.) Referral Services

As part of the enrollment and customer service processes, the HBM will identify factors associated with individuals in the target population that represent potential barriers to accessing health care services. In such cases, the HBM will have in place systematic procedures to provide information to the client about available services from other private and public social and human services agencies that may address or alleviate the potential barrier to care.

c.) Grievances and appeals.

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The HBM will develop, implement, and maintain ongoing grievance procedures based on written policies, developed by the HBM, for the filing, receipt, prompt resolution, and documentation of all grievances by clients that arise with regard to HBM policies or procedures. A grievance is defined as a request for resolution by a client who is dissatisfied with the services or materials received fiom the HBM. The HBM will also adjudicate grievances brought by clients against health plans that have not been satisfactorily resolved through the respective health plan grievance procedure. HBM grievance procedures will be approved by the State agency and include:

A standardized grievance process, including time frames for response.

Adequate assurances of confidentiality throughout the grievance process.

Procedures for routinely informing recipients of grievance procedures.

Establishment of an appeals process which will include at least one level of appeal beyond the initial level. Second level appeals must be adjudicated

by at least two members of the HBM's staff, including one person at the senior administrative level, governing board or equivalent.

Distribute copies of grievance procedures to enrollees as a routine part of the education process.

Periodically review the grievance procedures for the purpose of making changes to improve such procedures.

Designation of a staff member as the grievance representative who will be responsible for receiving and processing all client grievances.

After receipt of a grievance, acknowledge to the client in writing that the complaint has been received and the expected time frame for processing. The HBM will also inform the client in writing of the grievance resolution.

Ensure client access to all information to be considered by the HBM at the formal hearing.

The HBM must have the grievance procedures readily available in the member's primary language, and available for those with visual impairment.

Direct the client to the State agency's hearings officer to request a fair hearing, as appropriate.

The HBM's grievance procedures will not be a substitute for the State's current process, which provides an opportunity for a fair hearing before an impartial hearing officer to any person whose claim for assistance is denied or not acted upon promptly. The HBM must comply with State hearing rules and final hearing decisions and must agree to defend their findings in all State fair hearings by appearing or otherwise assisting the State.

Clients will have the right to file formal complaints and grievances with both the HBM and the State. These grievances may be filed simultaneously; however, the State encourages the HBM and client to resolve complaints before State intervention is requested.

d.) Health Plan transfers

The term "transfer" is used to refer to clients who leave one health plan to enroll in another health plan, all within the Diamond State Health Plan. Clients may request transfers between health plans during an annual one month open enrollment period for any reason. Clients may request transfers between health plans at any time for good cause. There is no limit on the number of transfer requests that a client can

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initiate for good cause. Health plans may also initiate a request for transfer with the State agency. The HBM will process and complete within five (5) business days of receipt all client and State agency-approved health plan requests to transfer clients to another health plan.

In the event that a health plan ceases to operate as part of the Diamond State Health Plan, the HBM will process and complete within fifteen (15) business days of receipt all transfer requests fiom all affected clients. In this case, any affected client who does not make a choice will be assigned by the State agency to one of the remaining health plans according to standard automatic assignment procedures. 9.13

e.) Disenrollments.
The term "disenrollment" is used to refer to clients who no longer receive services under the Diamond State Health Plan. The State agency is responsible for approving and processing all disenrollments. Upon receipt of information fiom the State agency that a disenrollment has occurred, the HBM will notify the client of the disenrollment. 3.07

f.) General problem resolution.
The HBM will mediate, when requested by clients, in the resolution of problems relating to the accessibility of health care system, including, but not limited to:

non-emergency medical transportation service issues;

handicap accessibility issues and other potential barriers to accessing the health care system,

unreasonable waiting times for appointments, and

non-clinical service disputes between a client and a health plan or provider This mediation will not be a substitute for the formal health plan grievance process.

The HBM will also maintain on ongoing referral process whereby situations which are reported by clients that involve circumstances that are more appropriately handled by the respective health plan's or the State agency's grievance process are promptly reported to the health plan or the State agency.

4. Administrative duties.

A. Administrative components.

The HBM will have in place sufficient administrative staff and organizational resources to comply with all contractual obligations. The HBM's organizational structure will include:

A full time Project Manager with clear authority over all staff, activities and associated functions described herein. Project Manager has have management experience and knowledge of Medicaid and managed care organizations.

Enrollment staff and clerical staff in sufficient numbers to handle the actual volume of mail applications, phone calls, and in person encounters during all phases of the contract. The level of HBM effort will be more intense during the initial conversion phase of the project than during the ongoing enrollment phase. Enrollment staff should have the following skills and abilities:

Strong interpersonal and communications skills.

Ability to maintain client confidentiality standards.

Ability to use HBM's computer system.

Adequate ability to recognize and respond appropriately to the cultural and ethnic diversity, as well as the health care needs of the client population.

Adequate linguistic capabilities (as a work force) to address the translation needs of the client population.

Program, procedures and systems documentation.

The HBM is responsible for providing to the State agency complete, accurate, and timely documentation regarding HBM systems and processes. Five (5) copies of such documentation will be provided to the State in final form within sixty (60) calendar days of the date of the State approves implementation of the HBM program as proposed by the HBM.

Any other material changes which occur to HBM operations will be documented and documentation of those changes must be provided to the State within thirty (30) calendar days of State approval of implementation of the change.

B.) Staff training program.

The HBM will have in place at least two months before enrollment begins a comprehensive staff training program. This program must be completed by all enrollment staff prior to assuming their assigned duties. Within the parameters, specified below, the HBM may design the staff training program to maximize the effectiveness of enrollment and support staff The State agency will review and approve the training curriculum before it is enacted. The staff training program will also have a refresher course designed to address program and policy changes, as well as new processes incorporated by the State or HBM. The training program should also have a remedial component. The HBM should indicate a proposed training schedule. The training program will include, at a minimum, modules that address:

General orientation; including the purpose and functions of the Health Benefits Manager;

Orientation to Medicaid and the Diamond State Health Plan, including the program's mission/goals, social and demographic characteristics of the client population, and agency administrative structure;

Customer service protocols, including telephone etiquette and grievance procedures;

Managed care education and orientation to participating health plans;

HBM computer systems;

Confidentiality issues;

Enrollment processes and procedures; and.

Specific job duties, functions and responsibilities.

C.) Maintain provider directory. 3.13

The HBM will maintain and provide access to all existing and potential enrollees, via mail and the telephone hotline, the following directories:

A directory of all the hospitals that are available within each health plan's provider network.

A directory of every primary care provider currently participating within each health plan's network, along with current information that indicates whether the provider is accepting new patients.

A directory of all other specialty providers participating in each health plan's network.

Each participating health plan in the Diamond State Health Plan will be required to furnish this information, via electronic media, to the HBM on at least a monthly basis.

D.) Logistical responsibilities.
The HBM will maintain the following services and facilities:

Toll-free telephone system.
The HBM will establish and operate a toll-free telephone center to answer questions about the Diamond State Health Plan. This system will be equipped with Automated Call Distribution equipment and must be capable of handling the expected volume of calls, including peak period volume. Telephone Device for the Deaf (TDD) equipment should also be utilized in the telephone center. Language translation services comparable to those offered by the AT&T language line service must also be available to clients through the toll free telephone system. Phone center hours of operation will be 8:00 AM to 8:00 PM Monday through Friday, or Saturday 8:00 AM to 12:00 noon, excluding State observed holidays.

The telephone system will be capable of transferring calls to the State agency, if necessary, without requiring callers to place another call.

The telephone system reporting capabilities in order to monitor the following performance standards. If telephone center performance fails to meet these standards for more than three consecutive calendar days, HBM staffing levels or equipment will be adjusted to meet demand, or other remedies should be proposed by the HBM.

At least 90 percent of all calls answered on or before the fifth ring.

At most 5 percent of all calls lost.

E. Office locations.
The HBM will establish a central business office within the State. Service office hours of operation should be at least 8:00 AM to 5:00 PM Monday through Friday, excluding State-observed holidays.

During the initial conversion phase of the program, co-location of HBM staff within State service centers and community service agency locations is desirable.

F. Communications activities.
The HBM will assign staff as necessary to engage in the following activities in order to assure the proper operation of the HBM program:

Participation in State/health plan/HBM operational work group.

This work group will review current operations on a regular basis for the purpose of identifying and resolving problems associated with enrollment and related processes. The HBM will have in place an internal system for systematically identifying problems and potential solutions for use in this forum.

Interface with health plans.
The HBM will conduct the following activities in cooperation with all contracted health plans.

Joint HBM/health plan workshops.
The HBM will engage in the joint design and operation of cooperative workshops with all participating managed care organizations to train enrollment staff in the features and procedures of each managed care organization's program product. These workshops must be attended by all enrollment staff upon initial employment and subsequently at least once during each twelve months of employment.

Participation in health fairs.
The HBM must have sufficient staff and materials present at all State agency sanctioned events where contracted health plans present products and services to potential clients.

G. Contract management.
The HBM will designate to the State agency a liaison, located in the HBM's main office, to facilitate the management of this contract. This person will be authorized to represent the HBM in all matters relating to the provisions of the contract. Other duties of this representative include

producing all contract deliverables as specified, responding to State agency requests in a timely fashion, coordinating ad hoc problem solving efforts with the State/health plan/HBM work group, and ensuring that adequate internal tracking mechanisms are in place to monitor contract compliance.

In no instance will the HBM refer any matter to the State agency or other Delaware state official unless initial contact, both verbal and in writing, regarding the matter has been presented to the State agency project manager or designee.

H. Improvement goals and corrective action plans.
The HBM will submit to the State agency on at least a quarterly basis a set of improvement goals that, if achieved, will result in tangible improvement in the services delivered to the client population. The activities necessary to achieve the goals must not increase the costs to the State agency in any way. These goals should be consistent with the actions of the State/health plan/HBM work group. The first set of improvement goals must be submitted within 60 calendar days of the completion of the initial conversion phase. The goals should also indicate actions planned to achieve those goals and specific timeframes for completion.

During the course of the contract, any significant deficiencies noted by the State agency that arise with respect to HBM performance will result in the HBM submitting to the State agency a corrective action plan This plan must analyze the problem and formulate the best solution to that problem from both the HBM's and State's perspective. The State agency project manager will determine the appropriateness of the analysis and proposed solution contained in the corrective action plan. Once approved by the project manager, progress towards completing the corrective action plan will be monitored by the State agency.

I. Perform HBM effectiveness survey.
The HBM will design and administer a client survey designed to measure client experience and satisfaction with HBM staff and services. The survey must be administered annually to a statistically valid random sample of clients who are enrolled in health plans at the time of the survey. The HBM will determine the appropriate sampling methodology, including the number of clients to be surveyed. The State agency will approve the final survey tool and methodology. The survey must contain items designed to measure at least the following dimensions of client satisfaction with HBM services:

Overall satisfaction with HBM's enrollment process;

Client knowledge of managed health care fiom a patient's perspective;

Client knowledge of rights and responsibilities, including knowledge of grievance procedures and transfer process;

Client perception of accessibility to HBM services, including the mail enrollment process, the toll fiee telephone system; and the customer services provided by the HBM;

Other factors that may be requested by the State agency.

The HBM will interpret and summarize the survey results using commonly accepted statistical compilation methodologies. The results should be reported both on a total basis and all other meaningful bases. Survey results must be submitted to the State agency no later than ninety (90) calendar days after the end of each annual contract period.

J. Computer and information interchange standards.
The **HBM** will have adequate personnel and resources in place to meet the following standards and procedures regarding receipt, processing and transmission of program information. All HBM staff must have access to equipment, software and training necessary to accomplish their stated duties in a timely and efficient manner. The HBM will supply all hardware, software, communication and other equipment necessary to perform the duties described below:

The **HBM** will receive daily via electronic media a file of all newly eligible Medicaid clients for enrollment into the Diamond State Health Plan.

During the initial conversion phase, the HBM will receive one or more roster(s) of all existing Medicaid eligibles at the beginning of the period. The client records contained on these roster(s) will correspond to the initial conversion schedule agreed to jointly by the HBM and the State agency. Thereafter, during the remainder of the initial conversion period, the HBM will receive eligible information monthly until the Diamond State Health Plan commences operation.

The HBM will provide to the State agency on a weekly basis, updates of all completed enrollment information. The HBM will be given on-line access to the Delaware Medicaid Management Information System *(MMIS)*

system in order to facilitate the transmission of this information. This information must be transmitted to the State no later than five (5) business days after receipt of completed enrollment information by the HBM.

The HBM will also generate and send, on a weekly basis, confirmation letters to all clients who have been enrolled into a participating health plan. This letter must be sent to the client no later than five (5) business days after receipt of completed enrollment information by the HBM.

The HBM will provide to the State agency on a weekly basis, updates of all Third Party Liability information as collected pursuant to requirements described elsewhere in this RFP.

The HBM will implement adequate security provisions and procedures in order to maintain client confidentiality. The HBM will also adhere to all applicable State agency procedures and restrictions associated with the access and update capabilities of State maintained information systems and databases.

5. Management reporting.

The HBM will design and maintain reports and logs as part of its overall contractual duties. The format and frequency of these reporting activities may change depending upon the nature of the winning proposal.

The State agency reserves the right to request additional or different management reporting information from the HBM throughout the contract period, on either an ad hoc or a regular basis. This additional information may be needed to address areas of interest regarding specific HBM performance or contract administration, or for policy analysis purposes.

The following reports are due from the HBM:

Monthly reports, due by the fifteenth of the month for the preceding month's activity, that show:

The incidence of voluntary selection and default selection of health plan for all clients assigned to the HBM for enrollment. The report should show the distribution of time elapsed between client notification and receipt of enrollment information, and be broken down by method of communication (mail, phone, etc.) and relevant demographic variables.

The incidence of voluntary selection of a primary care provider by all clients assigned to the HBM for enrollment, and be broken down in a similar manner to other reports described in this section.

The incidence of client requests for transfers between health plans, and State and health plan requests for disenrollment from the program. The report should show the distribution of time elapsed between request and the completion of the request, and be broken down by reason for the request and other pertinent variables. The report should also give similar information on pending requests for transfer and disenrollment.

Expenditures for the preceding period for each budget category as defined in the cost proposal work sheets. The report should indicate areas of significant variance (from the HBM's perspective) from planned expenditures in this period for each budget category.

The number of applications for exemption from mandatory enrollment, both completed by the HBM and pending. The report shown be broken down by the reason for exemption, and other relevant demographic and program variables.

The number of automatic re-enrollments completed by the HBM. The report should show the distribution of time elapsed between prior loss of eligibility and resumption of coverage, and be broken down by health plan and other relevant program variables.

Logs of each client grievance, including all relevant information about the grievance and the status of the grievance at the time of the report.

Logs of all undeliverable mail returned to the State agency.

Weekly reports, due by the end of the calendar week for the preceding week's activity, that show:

The performance of the toll free telephone system, including information that shows the number, length and type of calls received during the period, the number and percentage of

calls answered by the 5th ring, and the frequency of lost calls, and the average number of calls put on hold and the average amount of time that callers remain on hold.

Logs of all customer service and referral contacts including, at a minimum, the date, client name, HBM staff involved, the nature of contact or inquiry, and action taken by HBM staff, and the current status of the contact.

6. Records Retention Period

The HBM will retain all records and source information associated with reports and logs detailed in this section for the entire duration of the contract. The retention methods used will ensure that retrieval of any record or log, or portion thereof, can be accomplished within ten (10) business days of initial request of that information, whether by HBM or State agency staff. This capability may be necessary for contract administration purposes, data validation purposes, litigation purposes, or in order to assure compliance with governmental or other audit standards and practices.

The record retention methods will also be configured such that all necessary information (as determined by the State agency) contained in any record or log can be transferred to a subsequent HBM without requiring manual or other reentry of information.

The HBM will maintain records of all formal and informal grievances and the resolution of the grievances. The State agency, upon receipt of records from the HBM, will retain records for five years following a final resolution of the grievance.

State agency staff or the project manager may identify a condition resulting fiom the HBM's non-compliance with the contract through routine monitoring activities. If this occurs, the State agency project manager will notify the HBM in writing of the contractual non-compliance. The State will also designate a period of time in which the HBM must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the HBM should remedy the non-compliance.

Section VIII Eligibility Simplification

The State believes this must be an item relating to another States Terms and Conditions. We have not provided a response to this Section.

Section IX Quality Assurance and Utilization Review System

"...develop a detailed plan ... for using encounter data to pursue health care quality improvement. ...[including] how the base line for comparison will be developed; what indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; how data will be validated and how monitoring will occur...what penalties will be incurred if information's not provided."

"...the State will provide its overall quality assurance monitoring program for the managed care organizations,. ...the State will provide detailed criteria for monitoring the financial performance and quality assurance for each [MCO]. ... include contingencies if provider networks are terminated or become insolvent."

1. Utilization Management and Quality Assurance

A. Quality Assurance Structure

The MCOs utilization management and quality assurance program will consist of internal monitoring by the MCOs, oversight by DSS and the federal government, and evaluation by an independent, external review organization (EQRO). All MCOs must have a quality assurance structure composed of:

An internal system of monitoring services

Designated staff with expertise in quality assurance

Written policies and procedures for quality assurance and utilization management

B. Quality Assurance and Utilization Management Systems

MCOs are required to establish, implement, and adhere to the Quality Assurance and Utilization Management review systems approved by the Department and based on the current HCFA guidelines (A *Health Care Quality Improvement System for Medicaid Managed Care* issued July 6, 1993) and will:

Ensure that health care is provided as medically necessary in an effective and efficient manner

Assess the appropriateness and timeliness of care provided

Evaluate and improve, as necessary, access to care and quality of care with a focus on improving patient outcomes

Focus on the clinical quality of medical care rendered to enrollees

Incorporate all the "Minimum Quality Assurance and Utilization Management Requirements".

MCOs will be held accountable for monitoring, evaluating, and taking action as necessary to improve the health of its clients under contract with DSS. MCOs will also be held accountable for the quality of care delivered by sub-contractors.

C. Quality Assurance and Utilization Management Policy and Procedures

MCO Internal policies and procedures must:

Assure that the utilization management and quality assurance committee has established parameters for operating and meets on a regular schedule which is at least quarterly.

Provide for regular utilization management and quality assurance reporting to the MCO management and MCO providers, including profiling of provider utilization patterns

Be developed and implemented by professionals with adequate and appropriate experience in quality assurance

Provide for systematic data collection and analysis of performance and patient results

Provide for interpretation of this data to practitioners

Provide for making appropriate changes when problems in quality of care are found

Clearly define the roles, fbnctions, and responsibilities of the quality assurance committee and medical director

Fostering cultural competency among providers.

D. Internal Quality Assurance and Utilization Management Program

MCOs will have an internal written quality assurance plan (QAP) that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas. Emphasis should be placed on, but will not be limited to, clinical areas relating to maternity, pediatric and adolescent development (including EPSDT), family planning and well-women care, as well as on key access or other priority issues for Medicaid patients such as reducing the incidence of sexually transmitted diseases, acquired immune deficiency syndrome, smoke related illnesses, etc.

E. Utilization Management

The MCO must have written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. As part of its utilization management function the MCO must also have processes to identify utilization problems and undertake corrective action.

The MCO will develop and maintain a Utilization Management Committee, this Committee may be combined with the Quality Assurance/Quality Improvement Committee in the beginning of the program, to oversee utilization management decisions. The committee must include membership by individuals representative of the organization's provider network. The committee must also participate in the development of utilization management policies and procedures. The MCO must also ensure that it has sufficient/appropriate staff and resources to perform utilization management functions.

In the beginning of the DSHP, the QA Committee and the UM Committee may be the same Committee. The need for separate committees will be coordinated with and approved by the State.

F. Provider Profiling

The MCO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to HCFA's "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for the States. The MCO also must have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the MCOs medical management standards.

G. Quality Assurance Report

In addition to internal monitoring of quality of care, plans will also be required to submit periodically to DSS reports regarding results of their internal monitoring. This will include the reporting format of The Health Plan Employer Data and Information Set (HEDIS), version 2.0 or subsequent revisions, National Committee of Quality Assurance, and other targeted health indicators that will be monitored by DSS as well as other specific quality data periodically requested by the federal government. The MCO must agree to submit a quality assurance report six (6) months after the contract effective date and semi-annually thereafter.

H. Outcomes Objectives

The State, in conjunction with the MCOs, will develop a system of incentives for reaching outcome objectives in certain key areas to be defined by the State and MCOs. These outcome objectives will include, at a minimum;

childhood immunizations,
prenatal care,
birth outcomes, and
pediatric asthma management.

MCOs will be required to submit on a periodic basis objective numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. The DSHP will also coordinate with the Division of Public Health to assure that Healthy Delaware 2000 goals are met.

I. Internal Staff

The MCO will designate a quality assurance and utilization management coordinator, who is either the MCO's medical director or a person who directly reports to the medical director. This individual is responsible for the development and implementation of the quality assurance program. The coordinator must have adequate and appropriate experience in successful utilization management and quality assurance programs and be given sufficient time and support staff to carry out the MCOs utilization management and quality assurance fbnctions.

J. Quality Assurance Committee

MCOs must have a quality assurance committee that assists the coordinator in carrying out all quality assurance fbnctions. This committee must, at a minimum:

Have oversight responsibility and input on all quality assurance and utilization management activities

Have accountability to the MCOs governing board

Ensure membership on the committee and active participation by individuals representative of the MCOs provider community

Secure adequate insurance for members of the committee and subcommittees

K. Quality Assurance and Utilization Management Coordinator

The coordinator need not serve full time nor be a salaried employee of the MCO, but the MCO must be prepared to demonstrate it is capable of meeting all requirements using a part-time or non-employed director. The coordinator and the quality assurance committee must be accountable to the MCO's governing body.

The coordinator must:

Be licensed to practice medicine in the United States and be board-certified or board-eligible in his or her field of specialty

Be responsible for developing the MCO's annual written quality assurance description including areas and objectives, scope, specific activities, and methodologies for continuous tracking, provide review and focus on health outcomes

Be responsible for the MCOs utilization management and quality assurance committee, direct the development and implementation of the MCOs internal quality assurance plan and utilization management activities, and monitor the quality of care that MCO clients receive

Oversee the development of clinical care standards and practice guidelines and protocols for the MCO

Review all potential quality of care problems and oversee development and implementation of continuous assessment and improvement of the quality of care provided to clients

Assure that adequate staff and resources are available for the provision of proper medical care and health education to clients

Specify clinical or health service areas to be monitored

Specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by DSS as well as for areas the MCO selects; current Health Plan Employer Data and Information Set standards must be used

Be involved in the management of the MCOs EPSDT program

Oversee the MCOs referral process for specialty and out-of-plan services; all denied services must be reviewed by a physician, physician assistant, or advanced nurse practitioner; the reason for the denial must be documented and logged; all denials must identify appeal rights of the client

Be involved in the MCO's recruiting and credentialing activities

Be involved in the MCO's process for prior authorization and denying services

Be involved in the MCO's process for ensuring the confidentiality of medical records and client information

Be involved in the MCO's process for ensuring the confidentiality of the appointments, treatments, and required State reporting of adolescent sexually transmitted diseases

Work with the special programs coordinator to assure that reports of disease and conditions are made to DSS in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies

Assure that control measures for tuberculosis, sexually transmitted diseases, and communicable disease are carried out in accordance with applicable laws and guidelines and contained in each provider manual

Serve as a liaison between the MCO and its providers and communicate regularly with the MCOs providers, including oversight of provider education, in-service training, and orientation

Be available to the MCO's medical staff for consultation on referrals, denials, complaints, and problems

Attend State medical director's meetings

Maintain current medical information pertaining to clinical practice and guidelines

Attend grievance committee meetings when necessary

L. External Quality Assurance Reviews

DSS will contract with independent, external evaluators to examine the quality of care provided by **MCOs.** The Health Care Financing Administration also will designate an outside review agency to conduct an evaluation of this program and its progress toward achieving program goals.

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The MCO will be required to cooperate with any external quality, independent assessment (EQRO) of its performance which has been duly authorized by DSS. Independent assessments will include, but not be limited to, the federally required reviews of (1) access to care, quality of care, cost effectiveness, and the effect of case management; and (2) consumer satisfaction surveys.

The **MCO** will assist in the identification and collection of any data or medical records to be reviewed by the independent assessors and/or DSS.

The MCOs will have data. Medical records and space available for the EQRO when necessary.

M. DSS Monitoring and Oversight

DSS will monitor the **HBMs** enrollment processes, quality assurance procedures, implementation of the procedures, and the quality of service provided.

DSS will monitor each MCOs adherence to QARI standards through one or more of the following mechanisms:

Review of each MCO's written ***QAP*** prior to contract execution

Periodic review of numerical data and/or narrative reports describing clinical and related information on health services and

outcomes of health care for the Medicaid enrolled population. This will be accomplished in part through evaluation of encounter data submitted by MCOs.

On-site monitoring by DSS of QAP implementation to ensure compliance with all standards; such monitoring will take place at least once every six (6) months

Independent, external review of the quality of services furnished by each MCO, conducted by an entity under contract to DSS; such reviews will be conducted at least once each year; the MCO must agree to make available to the Health Care Financing Administration's outside review agency and DSS's external evaluator medical and other records (subject to confidentiality constraints) for review as requested

On-site visits and inspections of facilities

Staff and enrollee interviews

Review of appointment scheduling logs, emergency room logs, denial of services, and other areas that will indicate quality of care delivered to enrollees

Medical records reviews

All quality assurance procedures, reports, committee activities and recommendations, and corrective actions

Review of staff and provider qualifications

Review of grievance procedures and resolutions

Review of requests for transfers between primary care providers within each MCO

The MCO will submit a corrective action plan to resolve any performance or quality of care deficiencies identified by the independent assessors and DSS as determined necessary by DSS.

2. Reports of Fraudulent/Abusive Practices

The MCO will report any fraudulent or abusive practices by subcontractors, HBMs or providers to DSS for investigation or referral to other appropriate authorities and must cooperate with any subsequent investigation. The MCO and its providers are subject to review or investigation by DSS and other State agencies for quality of care, fraud or abuse, and must cooperate fully in the provision of requested information to offices, including but not limited to, DHSS, the Department of Justice, the State Auditor, the Insurance Department, and the appropriate licensing agencies within the Department of Administrative Services, as well as, reviewers from HCFA and/or Department of Health and Human Services.

Section X Administrative and Management System

We believe we have outlined this Section in Section I.

Section XI Encounter Data

" ...the State shall submit the proposed minimum data set and a workplan showing how the collection of plan encounter data will be implemented and monitored, what resources will be assigned to this effort and how the State will use the encounter data to monitor implementation of the project and [provide for program changes]."

" ...the State shall submit a plan for HCFA approval on how it will validate the completeness and accuracy of the encounter data."

1. General Requirements

Delaware's managed care program is based on the belief that clients will enjoy better access to primary care and preventive services, will experience improved health status and outcomes, and satisfaction with the health care delivery system. To measure the program's actual accomplishments in each of these areas, MCOs will provide the State with uniform utilization, quality assurance, and client satisfaction/complaint data on a regular basis. Furthermore, MCOs will be required to report on behavioral health services, including information on behavioral health expenditures, enrollment, access, modality of care, length of stay, client satisfaction, specialty care, and summary data on behavioral health actual program performance with respect to service access and health status/outcomes. The components of the plan include: encounter reporting, summary utilization reports, focused quality of care studies, client satisfaction surveys, and grievance and appeals reports, access to care, medical outcomes, and health status.

A. Encounter Reporting

MCOs are responsible for submitting encounter reports for all services rendered that fall within the Basic Benefit Package. Encounter reports must be submitted monthly and no later than seventy-five (75) calendar days after the end of the period in which the encounters were processed. All encounters must be submitted in electronic or magnetic format.

DSS will gather and monitor encounter data from the MCO to assess over and under utilization. The format will be consistent with the formats and coding conventions of the HCFA 1500, UB92 and NCPDP Version 3.2 (once pharmacy is included in the Basic Benefit Package) if and until the State determines that another standardized form is more appropriate. Compliance with reporting requirements will be enforced by withholding a portion of the capitation payment until encounter data requirements are met.

Encounter data is a record of medical services provided to enrolled members. Encounters include:

Hospital Services
Surgery

Physician services, Primary care, specialty care, EPSDT
Services provided by alternative care providers, nurse practitioners, nurse midwives
Lab, x-ray and other diagnostic services
Durable medical equipment
All other services provided under the plan

Encounter data submitted to DSS will be edited for accuracy, timeliness, and completeness.

Required Field Descriptions and Record Layouts are attached (Attachment C) and were communicated to the MCOs via Addendum # 4 to the MCO RFP document.

Section XII Family Planning Services

"...a complete description of the expanded family planning benefit, the scope of services, the eligibility process and requirements for the two year benefit [including] a discussion of the infrastructure available to provide the services"

"...a written plan describing how family planning services will be available to DSHP enrollees, if [MCOs] chose not to contract with Title X programs. ...address how the confidentiality of enrollees ...will be maintained."

1. Family Planning

Although family planning services are included within the Basic Benefit Package, these services can be directly accessed by Medicaid individuals without prior authorization through any Medicaid provider (who will bill the MCO and be paid on a fee-for-service basis). Access to family planning services without prior notification is a federal law. Under 1987 OBRA Section 4113 (c) (1) (B), "enrollment of an individual eligible for medical assistance in a primary case management system, a health maintenance organization, or a similar entity will not restrict the choice of the qualified person, from whom the individual may receive services under Section 1905(a) (4)(c). Therefore, DSHP clients must be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including those outside the MCOs provider network, without prior authorization.

All contracting MCOs are required to provide their DSHP clients with sufficient information to allow them to make an informed choice including: the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider both within and outside the MCO's network of providers. In addition, MCOs must ensure that MCO network procedures for accessing family planning services are convenient and easily comprehensible to clients. MCOs must also educate clients regarding the positive impact of coordinated care on their health outcomes, so clients will prefer to access in-network services or if they should decide to see out-of-network providers, they will agree to the exchange of medical information between providers for better coordination of care.

In addition, all contracting MCOs are required to provide timely reimbursement of out-of-network family planning and related STD services consistent with services covered in their contracts.

Family planning services may be accessed through PCPs, OB/GYNs, Planned

Parenthood, Division of Public Health Clinics and other like agencies. While not necessary for the Family planning benefit, Planned Parenthood and the DPH clinics are encouraged to contract with the MCOs.

2. Definition of Family Planning Services for Purposes of Out-of-Network Reimbursement

For the purpose of out-of-network reimbursement, family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy These services include:

Health education and counseling necessary to make informed choices and understand contraceptive methods

Limited history and physical examination

Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods

Diagnosis and treatment of STDs if medically indicated

Screening, testing and counseling of at risk individuals for human immunodeficiency virus (HIV) and referral for treatment**

Follow-up care for complications associated with contraceptive methods issued by the family planning provider

Provision of contraceptive pills/devices/supplies (Prescription drugs are provided as a pharmacy benefit.)

Tubal ligation

Vasectomies

Pregnancy testing and counseling

Pap smear is included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines which specifies cervical cancer screening every one (1) to three (3) years based on the presence of risk factors (early onset of sexual intercourse, multiple sexual partners); however, Pap smear annual frequency may be reduced if three (3) or more annual smears are normal.

** Based on HCFA's Medicaid policies, STD diagnosis and treatment and HIV testing and counseling, provided during a family planning encounter, are considered part of family planning services.

Abortions are not considered family planning.

Conditions for Out-of-Network Reimbursement of Family Planning Services

All MCOs must reimburse out-of-network providers for family planning services rendered to enrollees. The following are the conditions under which family planning providers will be reimbursed for family planning services provided to DSHP clients:

The family planning provider is qualified to provide family planning services based on licensed scope of practice

The family planning provider must submit claims on appropriate MCO-specific billing forms

The family planning provider must provide medical records sufficient to allow the managed care plans to meet their case management responsibilities; if a client refuses the release of medical information, the out-of-network provider must submit documentation of such refusal

The family planning provider must obtain informed consent for all contraceptive methods, including

sterilization, consistent with requirements of Title 22 CCR, Sections 51305.1 and 51305.3

In order to avoid duplication of services, to promote continuity of care and achieve the optimum clinical outcome for DSHP clients, out-of-network family planning providers should demonstrate reasonable efforts in coordinating services with MCO providers and educate MCO clients to return to MCO providers for continuity of care.

3. Extended Family Planning Benefits

The State will be responsible on a fee-for-service basis for the reimbursement of family planning benefits for the extended 24 month benefit period. Upon notification of the expiration of Medicaid eligibility all eligible female members will be assigned an Aid category of F3. The monthly ID card with this Aid category will allow the submission of Family Planning claims to the State's Fiscal Agency for reimbursement.

Section XIII Financial Reporting

1. Financial Data Reporting

Regular reporting is necessary to assure the ongoing operation and financial integrity of participating MCOs. Because participating MCOs are required to be HMOs licensed in the State of Delaware, financial reporting requirements are intended to parallel those already required by the Delaware Insurance Department for ongoing monitoring and regulation of MCOs in Delaware.

Financial Data Reporting Requirements

Quarterly Financial Reports	Due Date
Balance Sheet	45 calendar days after quarter end
Income Statement	45 calendar days after quarter end
Statement of Cash Flows	45 calendar days after quarter end
Medical Claims Payable (RBUCs & IBNRs)	45 calendar days after quarter end
Medical Claims Lag Reports	45 calendar days after quarter end
Capitation Payment Report	45 calendar days after quarter end
Summary Reports	
Utilization Data Hospital Utilization Data PCP Data Specialist Data	45 calendar days after quarter end
Annual Financial Reports (Balance Sheet, Income Statement, and Statement of Cash Flows)	120 calendar days after year end
Audited Financial Statements including Management Letter Other Annual Summary and Detailed Analysis as Required by the Delaware Insurance Department (DOI)	On date filed with DOI

As part of its oversight activities, DSS will establish financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of MCOs regarding their Medicaid membership. The areas in which financial benchmarks will be developed include at least the following:

Current Ratio: current assets divided by current liabilities

Equity per Member: Equity, less on-balance sheet performance bond, divided by the number of clients at the end of the period

Administrative expenses as a percent of capitation

Gross Medical Expenses Percentage: Gross medical expenses divided by total revenue

Total Administrative Cost Percentage: Total administrative expenses, excluding income taxes, divided by total revenue

Received But Unpaid Claims Days Outstanding: Received but unpaid claims divided by the average daily medical expenses for the period, net or sub-capitation expense

Net medical costs as a percent of capitation

IBNR and RBUC levels, including days claims outstanding

Total Medical Claims Days Outstanding: Total medical claims liability divided by the average daily medical expenses for the period, net of subcapitation expense

Utilization Review and management Summary Reports

Section XIV Federally Qualified Health Centers

1. FQHC and RHC Reimbursement

There are two (2) entities in Delaware operating in Delaware as FQHCs, SouthBridge Medical Services (Henrietta Johnson) and Westside Health Service (both FQHCs) operate in New Castle County. One (1) RHC, Delmarva Rural Ministries, operates in Kent county.

These organizations currently serve a critical role in the Medicaid delivery system. The State must ensuring that the outreach, social support and translation services provided by these organizations (in addition to the clinical care) are present to at least the same degree under the Diamond State Health Plan. In order to accomplish this, all MCOs operating in the same county as a FQHC and/or RHC, with which they intend to contract, will have contractual arrangements which assure that FQHC(s) and/or RHC are reimbursed for services on either a capitated basis (with appropriate adjustments for risk factors) or on a cost-related basis.

Section XV Coordination of Providers

"...[the] plans to assure coordination of benefits between the managed care organization's primary care providers and [Nemours clinic's, school based health clinics, DE state agencies and fee-for-service providers, e.g. dentists, FQHCs.] ...[include] plans for monitoring utilization of services and ensuring against duplication of services."

Nemours will be part of the Managed Care, Primary Care Provider(PCP) network. (See Section XVI, below)

School based care will be monitored via the EPSDT/CSCRP Unit working with the PCP and the Integrated Service Information System (ISIS).

Nurses assigned to EPSDT will do focused matches of services paid to the schools, using the EPSDT referral system, ISIS and MCO records,

Most wrap-around services, when provided for children, require Prior Authorization and Encounter records will be available

Section XVI Nemours Program

"describe...the integration of the **DSHP** managed care organizations and the Nemours program"

1. Nemours **CHILD** Plan

MCOs are strongly encouraged to offer the Nemours CHILD Plan the opportunity to participate in their MCO's provider network. The Nemours **CHILD** Plan currently provides managed care to children under a separate Section 1115 waiver. The Nemours CHILD Plan is expected to be fully integrated into the DSHP **MCOs.**

The Nemours Foundation and the A.I.DuPont Institute of the Nemours Foundation will be contacting providers with the MCOs, as of implementation of the **DSHP** on January 1, 1996. Nemours is currently negotiating capitatied contracts with the selected MCOs.

The existing contract with Nemours will continue until expiration, July 1, 1996 to provide for required evaluations of the Nemours **CHILD** plan as it is converted **to** the **DSHP** waiver.